Michigan Patient Centered Medical Home (PCMH) Initiative Practice Transformation Collaborative

April 3-4, 2017

Michigan Department of Health & Human Services

Practice Transformation Collaborative: Learning Session 1

State Innovation Model
Patient Centered Medical Home Initiative

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Background: A look at the State Innovation Model

Michigan received a State Innovation Model grant from Centers for Medicaid and Medicare Services (CMS) to test care delivery and payment system changes.

- Strategies focus on moving towards cost-effective use of healthcare dollars overall in terms of patient experience and quality outcomes.
- System that coordinates care within the medical system to improve disease management and utilization; and out into the community to address social determinants of health.

Vision: A person-centered system that is coordinating care across medical settings, as well as with community organizations to address social determinants of health, improve health outcomes; and pursue community-centered solutions to upstream factors of poor health outcomes.

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The State Innovation Model

Care Delivery

Population Health

Payment Reform

Health Information Technology

Evaluation

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Future of Care Delivery?

Image Credit: Eileen Clegg, Visual Insight

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The PCMH Initiative Focus

Support Scale for What's Working	Encourage the "Next Step" for Advancement	Test Promising Practices Where Opportunities Exist
PCMH Recognition as a Foundation	**Team-Based Care Practices**	**Clinical-Community Linkages**
Advanced Access (24/7, Open Access, Non-Traditional Hours)	**Integrative Treatment Planning**	**Health Literacy and Social Determinants Perspectives**
Electronic Health Record and Registry Base Technology	Provider Collaboration and Integration	Patient-Reported Outcomes
Structured Quality Improvement Processes	**Robust Care Management and Coordination**	Referral Decision Supports
	Patient Education and Self-Care	
	Caregiver Engagement	
	Transitions of Care	
	Managing Total Cost of Care	
	Health Information Exchange Use Cases	
	Patient Experience Perspectives	
	Population Health Strategies	

Bolded items represent current areas of direct focus.

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What is Bringing Us Together: Practice Transformation

"Practice Transformation" or "PCMH Transformation" refers to the result of enabling a primary care Practice to use both educational and financial support to develop the following characteristics of the Patient Centered Medical Home:

1) infrastructure,
2) organizational, and
3) cultural changes

i.e., primary care provider-led; prepared and proactive care teams providing comprehensive, whole person care; coordination of care across healthcare settings; enhanced patient access; use of electronic technology; and development of a culture that encourages striving for continual improvement in patients' experience of care and health outcomes for the entire Practice panel, while reducing preventable costs.

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Refresher- PCMH Initiative Participation Agreement

- Practice Requirement, By *November 1, 2017*: "Complete the PCMH Initiative's <u>required Practice Transformation Objective (clinical-community linkage), including submitting practice transformation progress reporting </u>on a semi-annual basis."

- Practice Requirement, *During the Initiative*: "Complete the required Practice Transformation Objective (as defined in the Participation Agreement), demonstrate progress toward completing the Practice Transformation Objective selected from the Initiative's menu of objectives, and report progress in a manner defined by the Initiative on a semi-annual basis."

- PO Requirement (As Applicable): "Submit practice transformation progress reporting on a semi-annual basis for participating Practices which choose to pursue Practice Transformation Objectives in partnership with the PO."

- "Practice Transformation Objective" or "Transformation Objective" refers to the care delivery enhancements and/or quality improvement activities defined by the Initiative that a Practice undertakes as to improve quality, improve health outcomes (including patient experience), improve access to care, and/or reduce health care costs. A list of Transformation Objectives is provided in Appendix F of the Participation Agreement and on the SIM Care Delivery webpage.

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Practice Transformation Objectives

Clinical-Community Linkages	Telehealth Adoption	Improvement Plans from Patient Feedback	Medication Management
Population Health Management	Self-Management and Support	Care Team Review of Patient Reported Outcomes	Group Visit Implementation
Integrated Peer Support	Patient Portal Access	Cost of Care Analysis	Integrated Clinical Decision Making

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More Than a Flip of a Switch

Transformation requires:

- Changes in:
  o Scheduling
  o Access requirements
  o Coordination
  o Types of visits (i.e. group visits)
  o Provision of services (e.g. telehealth)
  o Practice management
  o Staff roles
- Incorporating population medicine
- Evidence based care
- Redefining patient visit
- Response to patient needs and events outside of the clinical setting

- New coordination points:
  o With other parts of the healthcare system
  o With partners outside of the healthcare system
- Team based care
- New strategies for patient engagement
- Use of Information Systems including leveraging Health Information Exchange
- Outcomes based staffing
- Quality Improvement at the point of care

Adapted from Initial Lessons Learned from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home ANNALS OF FAMILY MEDICINE MAY/JUNE 2009

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In This Together

- The Practice Transformation Collaborative supports:
  - o "Going beyond" Patient Centered Medical Home,
  - o Sustaining change, and
  - o Continuous quality improvement

- Provides participants the opportunity to work **together** to support successful practice transformation

- Key Partner: Institute for Healthcare Improvement (IHI)
  - IHI is a leading innovator, convener, partner, and driver of results in health and health care improvement worldwide

- How to Engage in this opportunity:
  - o Action Period Calls
  - o Learning Sessions
  - o Peer Coaching Calls

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Our Starting Foundation…
Patient Centered Medical Home

1. Comprehensive Care
2. Patient-Centered
3. Coordinated Care
4. Accessible Services
5. Quality and Safety

Patient Centeredness

- Oriented towards the whole person
- Created by partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values

"It's not about having the best practice, it's about having the practice that best serves the patient"
— *Julia Nagy*

Our Current State

- 2017 SIM PCMH Self-Assessment Survey:

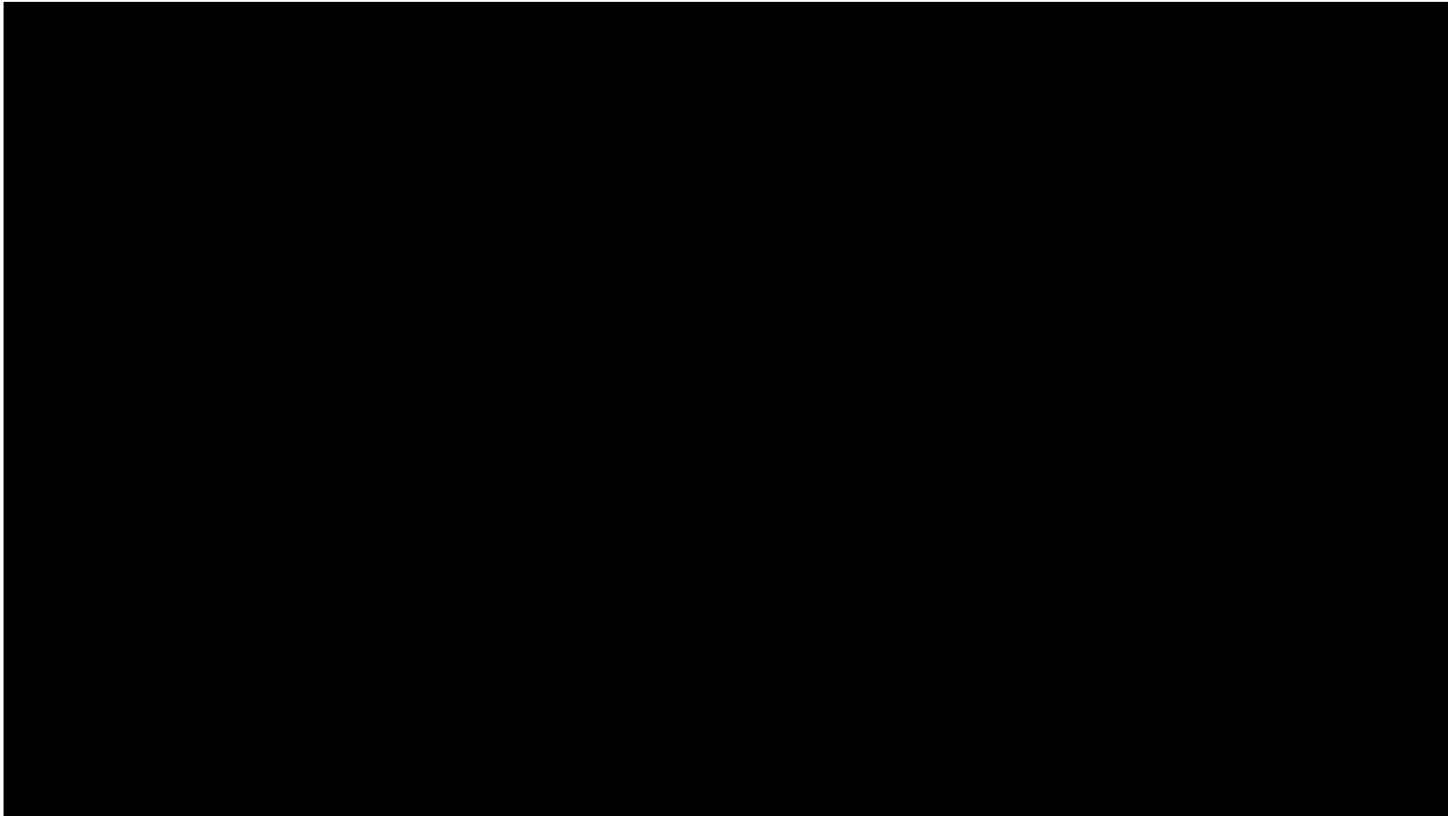| Question	Rating (1-5 scale)
A patient's individualized care plan is consistently developed by the interdisciplinary primary care team along with patient involvement.	3.89
Patient partnership in self-management support and collaborative goal setting is provided to patients and their involved caregivers by members of the practice team trained in patient empowerment and problem-solving methodologies.	3.47
Patient and Family Advisory Council and/or Patient and Family Advisor input occur through regular communication and meetings with patient and family advisors and/or advisory councils and has resulted in demonstrated improvements or changes.	2.51

"What matters to you?"

- 2012 NEJM article by Michael Barry and Susan Edgman-Levitan: "Ask 'What matters to you?' as well as 'What is the matter?'

- Through presentations and publications Maureen Bisognano, IHI President Emerita and Senior Fellow, has helped spread the idea globally

- "What Matters to You" Day began in Norway in 2014, and as of last year had spread to 500 international health care organizations

- June 6th, 2017

Michael J. Barry, M.D., and Susan Edgman-Levitan, P.A., "Shared Decision Making — The Pinnacle of Patient-Centered Care" N Engl J Med 2012; 366:780-781, March 1, 2012, DOI: 10.1056/NEJMp1109283

"Dolly" Jazz Singer

Think of a patient that faces multiple challenges. This is the patient that comes to mind immediately because their story is vivid and you worry about them.
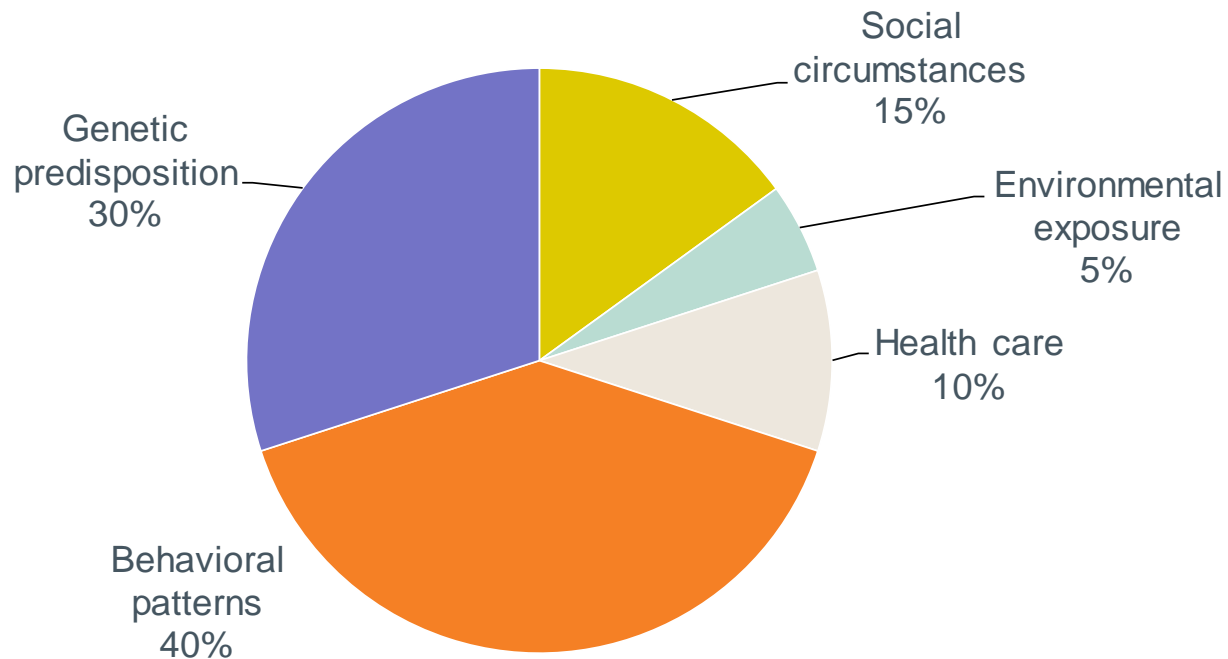
Share with a neighbor

Rayena

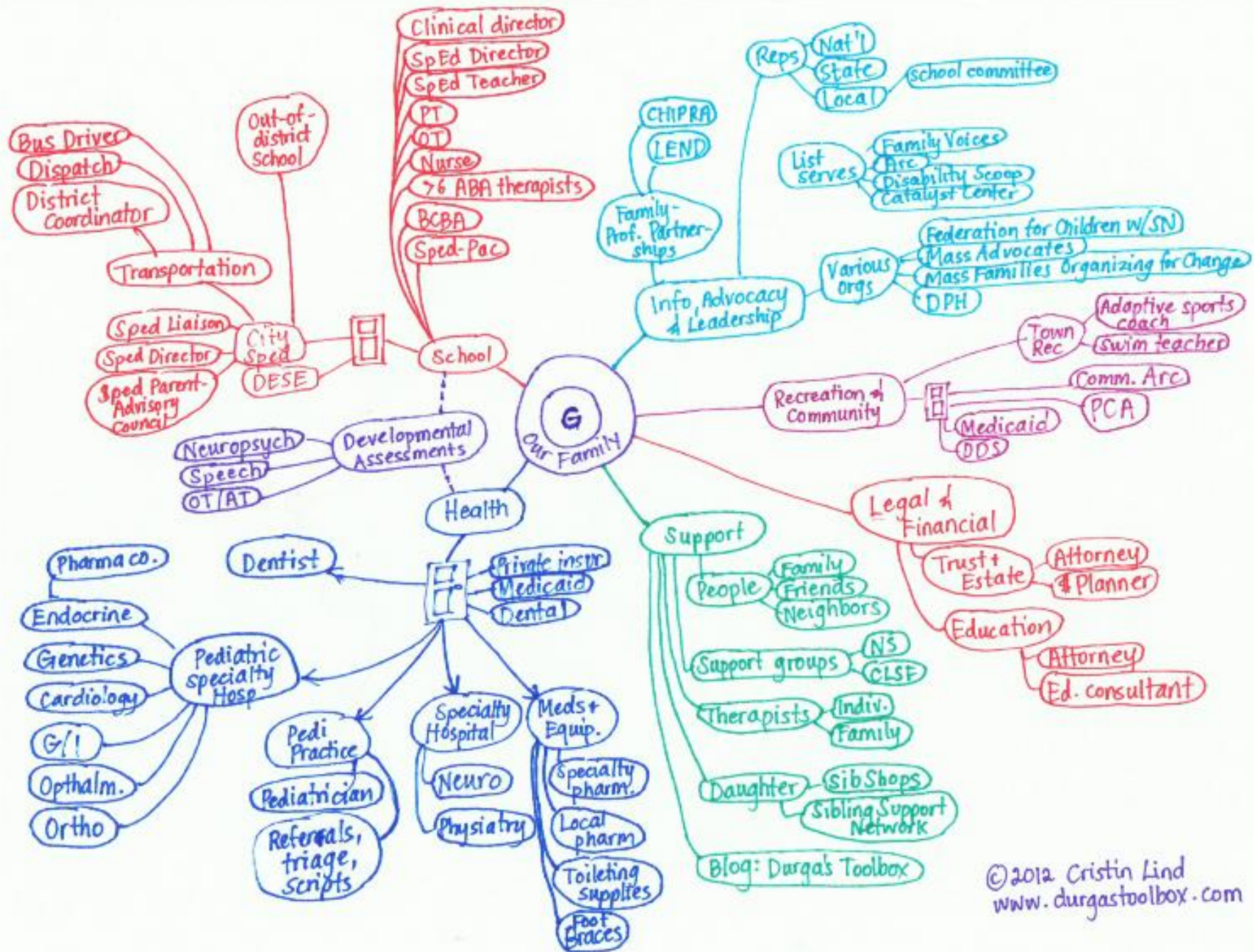What's missing from our definition of a PCMH?

Determinants of Health and Their Contribution to Premature Death

Proportional Contribution to Premature Death

Social circumstances 15%

Environmental exposure 5%

Health care 10%

Behavioral patterns 40%

Genetic predisposition 30%

Adapted from: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93.

5000 Hours

Source: Asch DA, et al. "Automated Hovering in Health Care – Watching Over the 5000 Hours." *New England Journal of Medicine*. July 2012: 367(1).

Mind map centered on "G — Our Family" with branches:

School (red)
- Transportation
  - Bus Driver
  - Dispatch
  - District Coordinator
- Out-of-district School
- Clinical director
- SpEd Director
- SpEd Teacher
- PT
- OT
- Nurse
- >6 ABA therapists
- BCBA
- Sped-Pac
- City Sped
  - Sped Liaison
  - Sped Director
  - Sped Parent Advisory Council
  - DESE

Developmental Assessments (purple)
- Neuropsych
- Speech
- OT/AT

Info, Advocacy & Leadership (teal/blue)
- Family-Prof. Partnerships
  - CHIPRA
  - LEND
- Reps
  - Nat'l
  - State
  - Local
  - school committee
- List serves
  - Family Voices
  - Arc
  - Disability Scoop
  - Catalyst Center
- Various orgs
  - Federation for Children w/SN
  - Mass Advocates
  - Mass Families Organizing for Change
  - DPH

Recreation & Community (pink/magenta)
- Town Rec
  - Adaptive sports coach
  - Swim teacher
- Comm. Arc
- PCA
- Medicaid
- DDS

Legal & Financial (red)
- Trust & Estate
  - Attorney
  - $ Planner
- Education
  - Attorney
  - Ed. consultant

Support (green)
- People
  - Family
  - Friends
  - Neighbors
- Support groups
  - NS
  - CLSF
- Therapists
  - Indiv.
  - Family
- Daughter
  - Sib Shops
  - Sibling Support Network
- Blog: Durga's Toolbox

Health (blue)
- Dentist
- Private insur
- Medicaid
- Dental
- Pediatric specialty Hosp
  - Pharma co.
  - Endocrine
  - Genetics
  - Cardiology
  - G/I
  - Opthalm.
  - Ortho
- Pedi Practice
  - Pediatrician
  - Referrals, triage, scripts
- Specialty Hospital
  - Neuro
  - Physiatry
- Meds + Equip.
  - Specialty pharm.
  - Local pharm
  - Toileting supplies
  - Foot Braces

© 2012 Cristin Lind
www.durgastoolbox.com

Do to   Do for   Do with

What might "better" look like?

Design with the individual…
Learn for the population

Design for the population…
Adapt with the individual

"We're not connecting a problem to a solution, we're connecting a patient to a solution."

– *Julia Nagy*

BREAK

Team Time: Eco-maps

Sue Gullo, Director, IHI
Sue Butts-Dion, Improvement Advisor, IHI

Institute *for*
Healthcare
Improvement
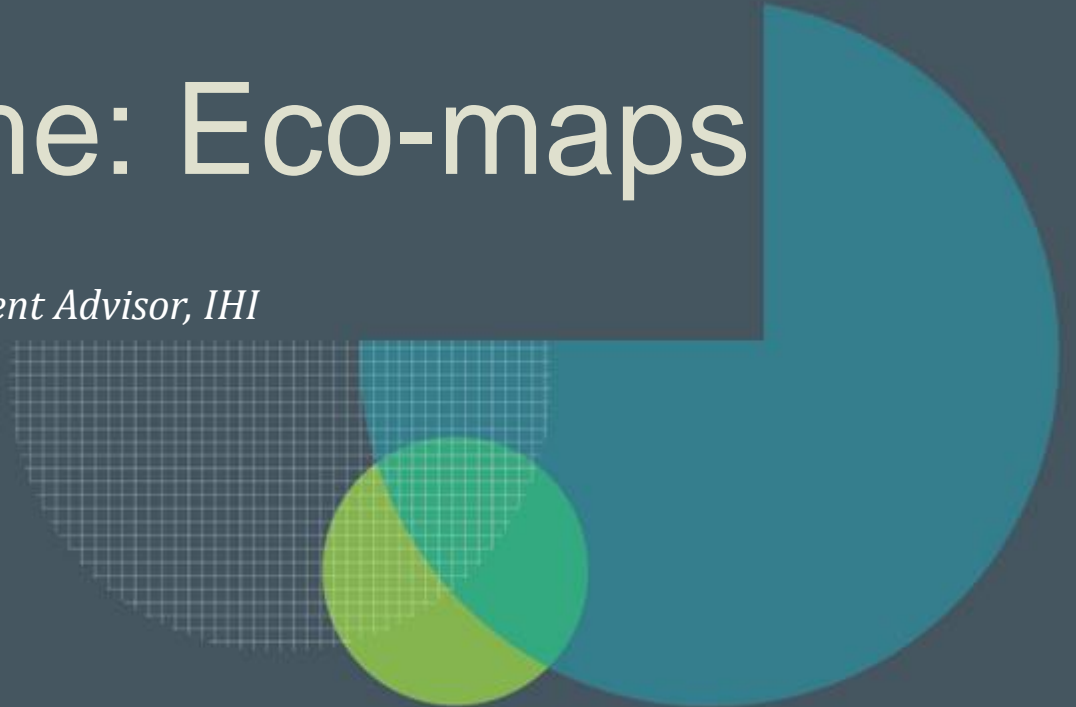
Objectives

- By the end of this session, participants will:
  - Understand systems mapping as a way to explore their own clinical-community relationships and a patient's "system" of social connections and potential gaps.
  - Learn how to use eco mapping as one way to reveal the need for additional partnerships and/or collaboration with resources to improve patient outcomes.
  - Use one case study to learn how looking at one patient can inform relationships that should be formed or nurtured on behalf of patients.
  - Think differently about ways to ask the patient what matters to them.

How we can look for potential linkages: System Mapping

- A simple map modeled after a Sociogram--a sociometric chart plotting the structure of interpersonal relations in a group situation.

- An eco-map--a graphic representation that shows the systems at play in an individual's life. Eco-maps are used in individual and family counseling within the social work and nursing profession. They are often a way of portraying Systems Theory in a simplistic way that both the social worker and the client can look at during the session.

Reference: http://en.wikipedia.org/wiki/Eco-map

First up—what does **your** current state look like?
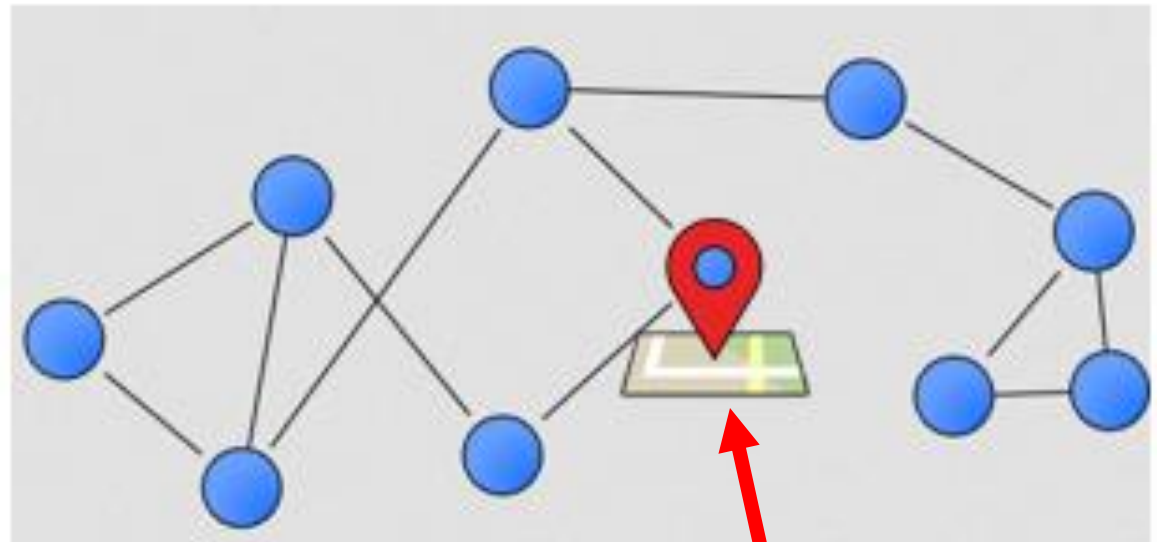
Your Organization

─────── = A Strong Relationship

━ ━ ━ ━ = A Weak/Vulnerable Relationship

⎯/⎯/⎯/⎯ = A Stressful/Adverse Relationship

◄───────► = Flow of Resources

CCL Questions for Consideration

● Linkages to strengthen?

  – How frequently do people in each of these groups communicate with you about patients?

  – How timely and accurate is their communication?

  – How do you make sure people in this group know about the work that you do? How do they know about the work they do? When was the last time you met in person?

  – How would you measure a "successful" linkage?

Now, through the patient's eyes…

- Using the case studies or the story of one of your own patients (please no names-just characteristics), map out the clinical-community relationships you may have or may need to strengthen or create on their behalf.

Case Study A

Dora is a 65 year old female who has been a patient in your clinic for 30 years. She presents for an annual Wellness Exam, but has not been seen in the clinic for over 2 years. She recently lost her husband to a heart attack. She is retired and lives alone. Her son and daughter live out of state.

Dora presents with a BP of 160/95 and a hemoglobin A1C of 10. 1. She was told in the past that she may be a pre-diabetic but hasn't returned to the clinic since. She is 50 lbs. overweight and does not like to exercise due to chronic knee pain. She does like to cook and is interested in healthy eating.

How do you ask Dora what matters to her? Describe the conversation as you both explore your priorities and her priorities. Knowing this, how could you work with her to get her BP and hemoglobin A1C under better control and enjoy a better quality of life? What clinical community linkages does she already have and how can you help her discover more?

Case Study B

Gregory is a 65-year-old farmer. He experienced his first heart attack at 45 y/o and had his first coronary artery bypass graft surgery (CABG) at 64 y/o. His primary care physician (PCP) and cardiologist are both located within 25+ miles of his home. The cardiac surgeon who performed his CABG is 200 miles away. Gregory was discharged to home after CABG with multiple medications and pages of instructions. Two weeks post-CABG, he experienced a productive cough, and "was not feeling right". He ended up being rushed to his local hospital by his wife early Monday a.m. and readmitted. He was discharged home with a different medical regime and more instructions for an office visit with his PCP.

Gregory's PCP received an ADT message and called to set up a same day appointment, at the appointment a Care Manager assisted in medication reconciliation. During this time, Gregory's wife, a nurse, was diagnosed with throat cancer and scheduled for radiation therapy every day for one month at the tertiary care center 120 miles away. Gregory is not able drive. Both are worried because of their finances due to inability to work. Children and PCP suggest they seek out financial assistance and perhaps some counseling but both too proud to do that.

How could your care team support Gregory and his wife? How will you ask what matters to them? What might be some community partners you could connect them with once you understand their needs?

Case Study C

Don is a 55 year old man who presents to the clinic. During Don's visit he completes a Social Determinants of Health (SDoH) brief screening, and a physical exam is conducted. Don has a BP of 170/100 with a history of depression and heavy alcohol use. He has been sober for 10 years. He had a heart attack at age 50 after a twenty year history of high cholesterol and high blood pressure. His fasting glucose suggests prediabetes.   He was on a blood pressure medication but stopped taking it due to the cost of the medication which was expensive with his high deductible plan.

He currently works as a trucker and works long hours driving. He rarely exercises. He lives with his wife. They are both 40-45 lbs. overweight.

What are non-clinical areas of focus with Don? What matters to Don in his life? How could you work with Don to identify community partners to get his BP and prediabetes under better control?

Case Study D

Cecilia, a 69 year old woman, presents to urgent care with severe shortness of breath and extreme swelling in her legs, ankles and feet. She reported that her breathlessness and coughing episodes had become particularly severe in the preceding 3 weeks and that she could not stand or walk for more than 1 to 2 minutes without becoming very tired. She has smoked 1.5 packs of cigarettes a day since she was in her early 30's. She is not taking any medications and claims to not be seeing a doctor right now. Deemed to be in acute respiratory distress and having severe chronic obstructive pulmonary disease (COPD), she was immediately sent to the local hospital. After three weeks of inpatient hospitalization, she was discharged to her home with noninvasive positive pressure ventilation and supplemental oxygen. She is scheduled for a PCP visit w/in one week of discharge. You are Cecilia's new PCP. During Cecilia's first visit, a Care Manager conducts a comprehensive assessment.

What matters to Cecilia? What might Cecilia's immediate needs be? What community linkages might be essential for Cecilia?

Through the patients' eyes…
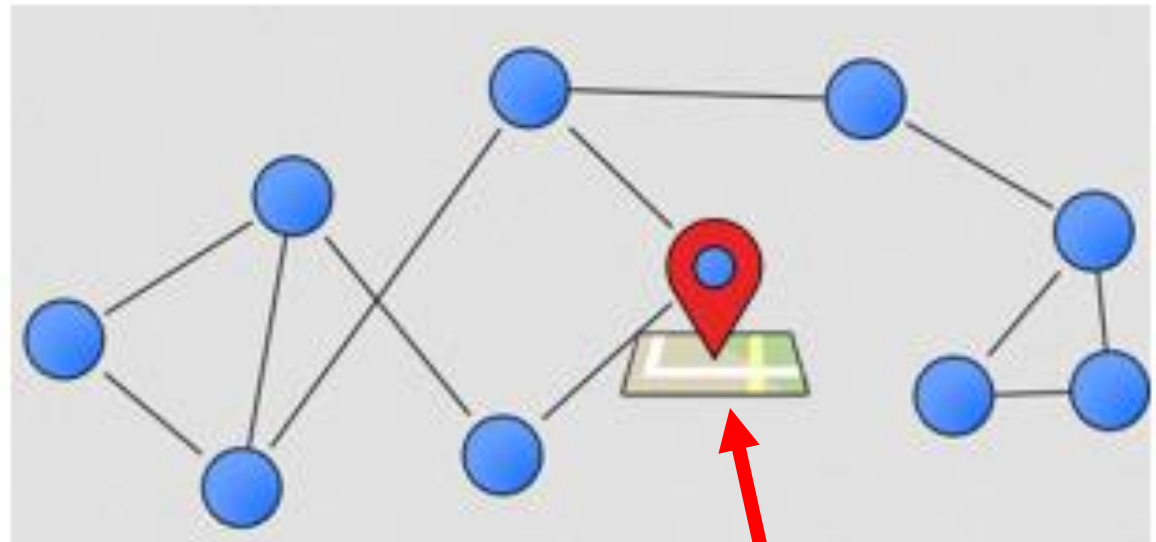
Patient

———— = A Strong Relationship

— — — — = A Weak/Vulnerable Relationship

—/—/—/— = A Stressful/Adverse Relationship

←——→ = Flow of Resources

CCL Questions for Consideration

- Linkages to strengthen on behalf of patient?

- Linkages to create?

- How could your practice/organization support this patient in a manner that is responsive, respectful of the patients and family's goals and ensures that feedback loops are closed?
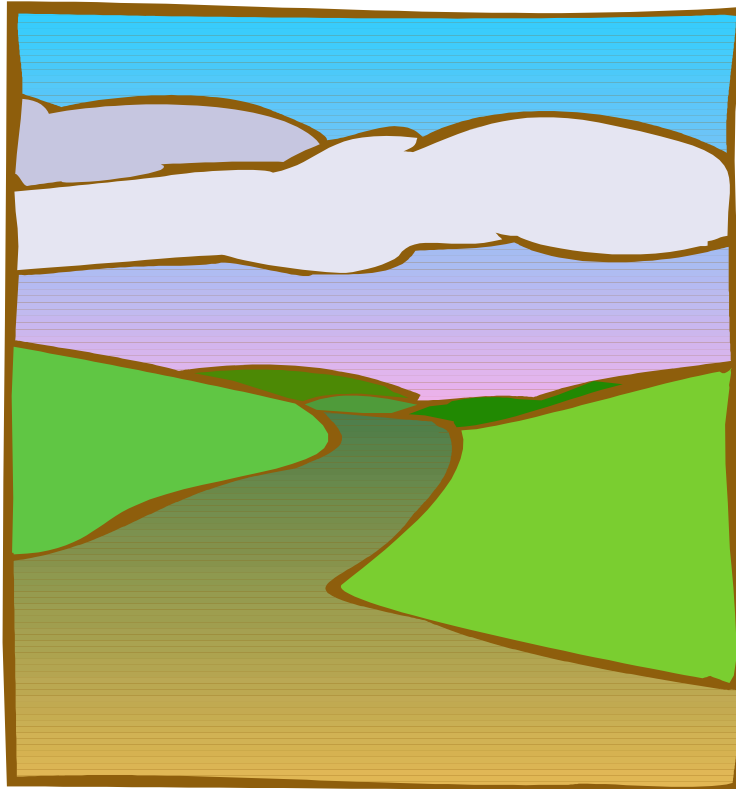
Question

- How might thinking about other patient populations in this fashion help you with your Clinical-Community Linkage obligation?

It's About the Journey

Debrief

What is it we are trying to accomplish? Creating the "Wall of Aims"

Sue Gullo, Director, IHI
Sue Butts-Dion, Improvement Advisor, IHI

Objectives

- By the end of this session, participants will:
  - Understand the importance of having aims
  - See how their aim fits with the aim of others in the Learning Community

MI PCMH Initiative: High Level Aim

- By November 1, 2017, participating sites will complete the PCMH Initiative's required Practice Transformation Objective (clinical-community linkages), including submitting practice transformation progress reporting on a semi-annual basis.

- Specifically, all sites will have systems in place to:
  - Use a brief screening tool with all attributed patients to assess patients' social determinants of health to better understand socioeconomic barriers.
  - Based on results of brief screening tool, provide linkages to community-based organizations including tracking and monitoring the initiation, follow-up and outcomes of referrals made.
  - Periodically review the most common linkages made and their outcomes to determine the effectiveness of the community partnership and opportunities for improvement and partnership expansion.

Every System Has an Aim
Cascading Aims

Overarching Aim—MI
PCMH Initiative

↓

Your Aim

What Are We Trying To Accomplish?

The AIM is

- Not just a vague desire to do better

- A commitment to achieve measured improvement

  - In a specific *system*

  - With a definite *timeline*

  - And numeric *goals*

    - *E.g. % of patients screened, % of patients appropriately linked to follow up (e.g., feedback loop closed)*

Organization Name: _____

Location: _____

- **Brief description of your organization:**

_____

_____

- **With regard to Clinical-Community Linkages:**

What do you hope to accomplish related to this objective?

_____

By how much do you hope to improve?

_____

And by when do you want to improve?

_____

Organization Name: _____
Location: _____

- **Brief description of** _____

  _____

  _____

- **With regard to Clinical-e**

  What do you hope to accomplish re

  _____

  By how much do you hope to improve?

  _____

  And by when do you want to improve?

  _____

If you've not completed, please draft now. If completing from an organizational perspective does not make sense for you, complete it from the perspective of the position you hold within the system. How can you contribute to the global aim—what is your aim?
Post on the wall.

Exercise: Part 1 (20 minutes)

- Your table is now your new work team
- Draft and share your aim with your team
- Give feedback to one another
- Tape your aims on one piece of flip chart paper

Exercise: Part 2 (20 minutes)

- Join up with another table—they are now your expanded team ☺

- Both take your flip charts and post them on a section of the wall

- At the wall, share & discuss your aims with the other team

Gallery Walk

- Time remaining and during breaks and lunch!
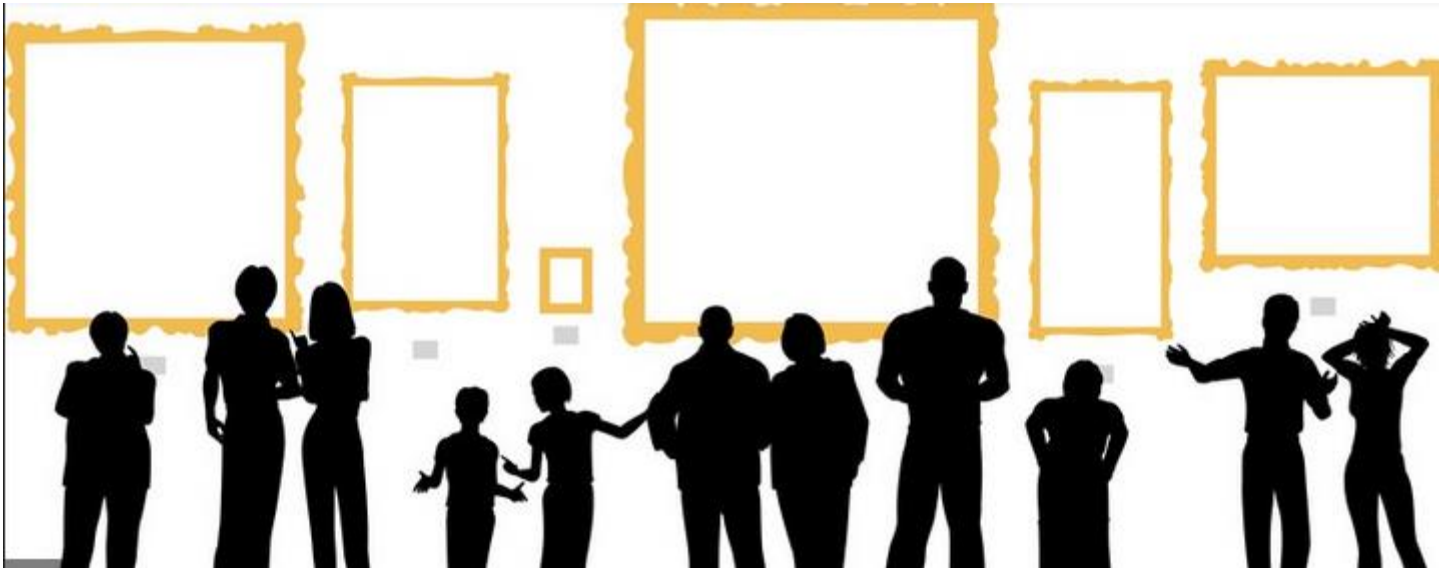
LUNCH

Objectives

● By the end of this session, participants will:

- Better understand the Clinical-Community Linkages expectation.

- Have identified things that are going well in relationship to it, what would ideally be right and identify gaps between the current state and ideal state.

Clinical-Community Linkages

- Future of the Medical Home model is also about relationships

- The effectiveness of the PCMH model to promote integrated, coordinated care throughout the healthcare system depends on the availability of a "*hospitable and high-performing medical neighborhood.*"
  - The New England Journal of Medicine, Elliott S. Fisher, M.D., *M.P.H.*

"The Patient-Centered Medical Home (PCMH) is a model of care that emphasizes care coordination and communication to transform primary care into "what patients want it to be."
Source: NCQA

Communities that are "Neighborly"

- Characteristics:
  - Trust
  - Mutual Respect
  - Safe
  - Leverage services
 - Agreements
  - Communication

Reflect on Systems Mapping

- Use the following questions to guide your café dialogue:
  1. Who do you need to be working with to make clinical-community linkages most effective for you and for patients?
  2. How will the medical home model change the type and scope of the services you are providing?
  3. How could relationships and collaboration between PCPs and specialists be strengthened? Between health care providers and uncommon partners (e.g., YMCA, community supports)
  4. How could your health information systems be more connected?
  5. How could you engage the patient and family in our work and "really" incorporate the voice of the patient in all that we do?
  6. Describe how you are educating the community about this new model.

The process…
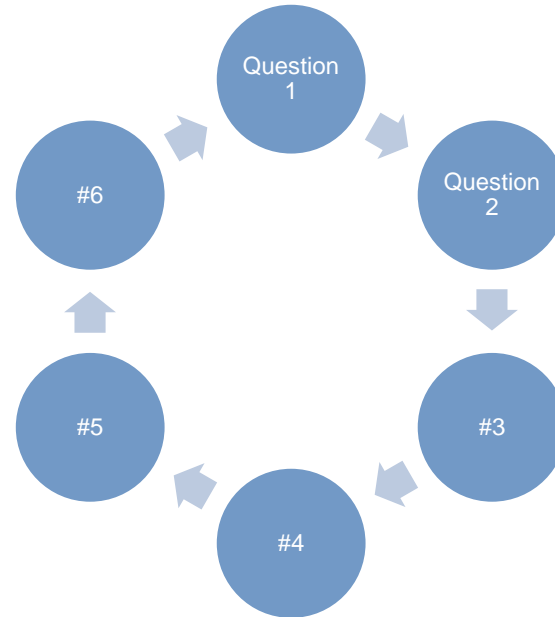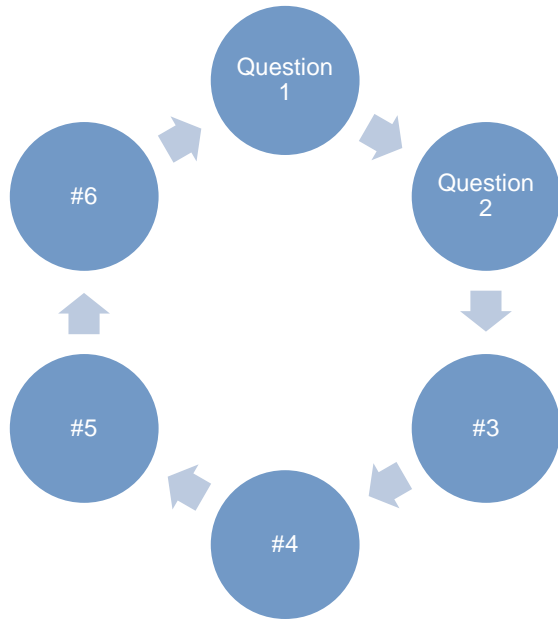
Back at your table--summarize

- What is going well (current state)?
- What would be ideally right (ideal state)?
- What are some initial ideas about how to close the gaps between the current state and ideal state?

Debrief

Break and Transition to Breakouts

- **University Ballroom (Red Dots):**
  - Assessing Social Determinants of Health
    - Phillip Bergquist, Manager, Policy and Strategic Initiatives, MDHHS
    - Katie Commey, SIM PCMH Initiative Coordinator, MDHHS

- **Beaumont Ballroom (Green Dots):**
  - Working with the Medical Neighborhood for Improved Continuity of Care and Patient Experience
    - Trissa Torres, Chief Operations and North America Programs Officer, IHI

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Assessing Social Determinants Of Health

Concurrent Breakout Session

SIM PCMH Initiative Practice Transformation Collaborative

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A Common Definition

"The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. "

But, you knew that already… so why are we talking about SDoH screening today?

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SDoH Screening

Clinicians have long recognized the connection between unmet basic resource needs – e.g. food, housing, and transportation – and the health of their patients. More than 70% of health outcomes are attributable to the social and environmental factors that patients face outside of their PCMH.

"One of the first steps to addressing social needs is asking your patients about this aspect of their lives."

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One Step Closer to Realizing a Vision

Creating effective linkages between clinical and community settings can improve patients' access to services by developing partnerships between organizations that share common goals. These linkages have many positive outcomes:

- Patients get more help and more broadly based support in changing unhealthy behaviors
- Clinicians get help in offering services to patients that they cannot provide themselves
- Community programs get help in connecting with clients for whom their services were designed
- Partnerships and relationships among clinical, community, and public health organizations are strengthened to better work together in filling service gaps
- Health care delivery, public health, and community-based activities are coordinated to maximize their impact

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PCMH Initiative CCL Objective

Develop documented partnerships between a Practice (or PO on behalf of multiple Practices) and community-based organizations which provide services and resources that address significant socioeconomic needs of the Practice's population following the process below:

1. **Assess patients' social determinants of health (SDoH) to better understand socioeconomic barriers using a brief screening tool with all attributed patients.**
2. Provide linkages to community-based organizations that support patient needs identified through brief screening, including tracking and monitoring the initiation, follow-up, and outcomes of referrals made.
3. As part of the Practice's ongoing population health and quality improvement activities, periodically review the most common linkages made and the outcome of those linkages to determine the effectiveness of the community partnership and opportunities for process improvement and partnership expansion.

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PCMH Initiative CCL Objective
Assessing Patients' Social Determinants of Health

- The intent of brief social determinants of health screening is to establish a <u>routinized process</u> through which providers identify (in an actionable manner) social barriers their attributed patient population is facing

- Use of the word <u>brief</u> reflects the idea that implementing this screening component of the CCL requirement should result in a concise look at patients' social needs rather than an in-depth assessment

- The brief screening will not take the place of deeper, more comprehensive assessment processes utilized as part of care management or mandated by other programs, but it should inform those processes

- The PCMH Initiative has provided a template screening tool to participating providers, however this tool can be altered to match local needs (e.g. changing how questions are phrased, varying how questions are categorized in domains, choosing different formats to administer the screening such as an EHR template or incorporating into existing patient questionnaires etc.)
  - PCMHs are discouraged from completely removing one or more of the topics/domains contained in the template, although combining and/or rearranging domains is permitted
  - PCMHs located in SIM/CHIR regions should work with their CHIRs (typically through a PO) to use the brief screening tool the CHIR in your area has/is developing

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Thinking About SDoH in Practice

Take a walk, read through one or more of the completed SDoH screenings posted on the walls. As you walk, imagine you're in a practice and have just received one of these screening forms from a patient:

What should you try to learn more about based on how your patient filled out the screening?

Keeping in mind what you learned from the screening, what could you do differently to better serve your patient?

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Screening Approaches

- **Patient Self Screening Followed By Staff/Clinician Review**
  - Example: A patient is handed a paper screening form during check-in to complete in the waiting room. The screening is given to a Care Coordinator for review before/during the patient's appointment.
- **Assisted Patient Self Screening Followed By Staff/Clinician Review**
  - Example: At check-in the patient is invited to take a seat in semi-private reception area to complete a paper screening form with a MA. The MA introduces the screening, why the practice is asking these types of questions, and answers questions the patient may have. The screening is given to a Care Coordinator for review before/during the patient's appointment.
- **Staff Administered Screening Followed By Staff/Clinician Review**
  - Example: As part of rooming a patient, a Medical Assistant introduces the screening, asks the patient a series of screening questions, and marks the patient's answers in the EHR. The EHR alerts a Care Manager that a screening is ready to review before/during the patient's appointment.
- **Staff Administered Screening and Review**
  - Example: Before/during/after the patient's appointment, a Care Manager introduces the screening, why the practice is asking these types of questions, and asks the patient a series of screening questions. The Care Manager marks the patient's answers in the CM system during the screening and takes action (as needed) on the results.

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Screening Tool Best Practices

- Takes less than five minutes to complete
- Presented in a format that works (and is comfortable) for your patients
- Available in multiple languages and large print sizes
- Easy, similar response options for each question (all Yes/No, Likert scale, etc.)
- Ideally questions come from clinically validated tools or measures
- Screening is written at a fifth grade reading level to be accessible for low literacy populations
- Focus on prevalence of need separately from interest in program enrollment
- Designed to open a conversation with your patient population
- Sequenced questions starting with relatively passive content to more sensitive content

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PCMH Initiative CCL Objective
Assessing Patients' Social Determinants of Health

- To successfully implement the CCL screening requirement, participating PCMHs should be actively implementing a screening plan and screening procedure on November 1, 2017 which addresses the entire attributed population
    - The Initiative does not expect all patients to be screened by November 1st, that date is the beginning of the screening process (screening a full attributed population for the first time may take up to 18 months)
    - The screening plan should, at a minimum, address:
        - The circumstances/visits during which PCMHs will administer screening
        - Anticipated time it will take to complete the first screening across the attributed population
        - The timing and process for ongoing patient screening
        - The approach to monitoring screening completion and closing screening gaps
    - The screening procedure should, at a minimum, address:
        - How and by whom (if applicable) screening is administered
        - How and by whom results are interpreted
        - How/where results are stored and made available to team members
        - The follow-up steps that are taken when screening reveals a social need
- During semi-annual progress reporting, the Initiative will request a copy of a PCMH's screening plan and screening procedure, the screening tool being administered and a total count of patients screened

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Thinking About SDoH in Practice

Take a walk, visit each of the idea boards and contribute an idea or example to at least one the following discussion topics:

- **Identifiable patient milestones, circumstances or types of appointments that can "trigger" patient SDoH screening**

- **Methods to electronically save, make available to your team or monitor the completion of SDoH screening in your practice**

- **Steps to take after a SDoH screening reveals a patient has one or more social needs**

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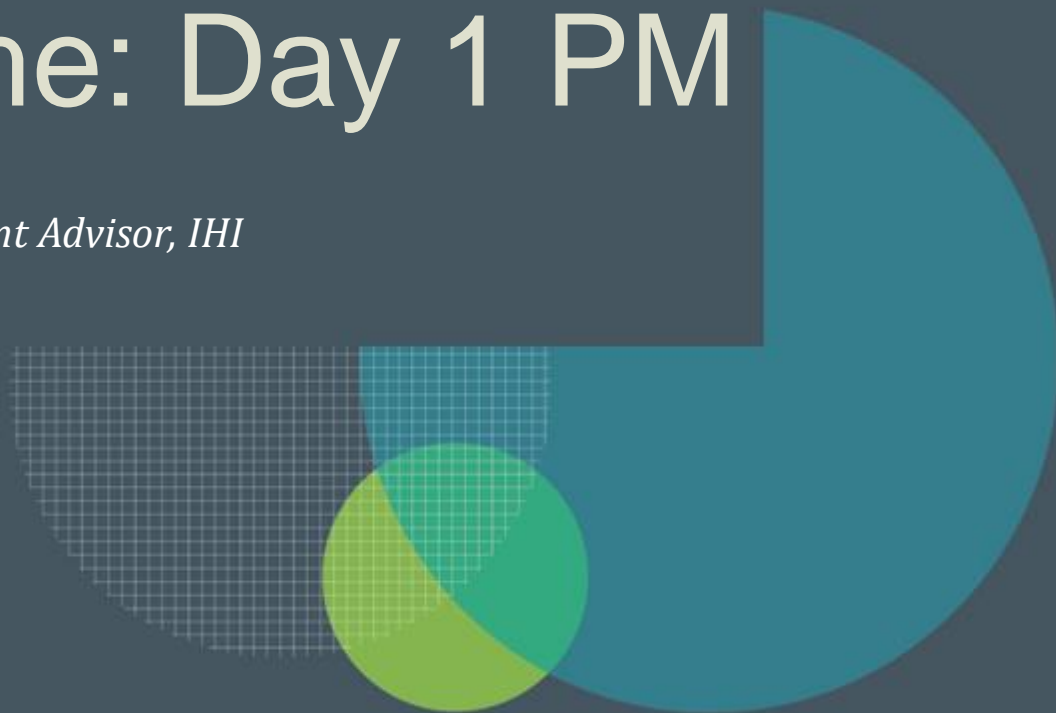
Assessing Social Determinants Of Health

Concurrent Breakout Session

SIM PCMH Initiative Practice Transformation Collaborative

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Objectives

- By the end of this session, participants will:
  - Better evaluate how their aim aligns with the transformation initiative aim
  - Alter their aim statements based on learnings from day

Organization Name: _____

Location: _____

- **Brief description of your organization:**

  _____

  _____

- **With regard to Clinical-Community Linkages:**

  What do you hope to accomplish related to this objective?

  _____

  By how much do you hope to improve?

  _____

  And by when do you want to improve?

  _____

Based on your initial aim…

- **Given what you have learned today:**
  - Which goal do you think will be your easiest to accomplish and why?
  - Which do you think will be your hardest goal to accomplish and why?
- **Is your goal still achievable and realistic in the time frame you had indicated?**
- **Could you do more? Are you expecting too much?**
- **Who must you make sure knows about and supports the aim?**
- **What support do you anticipate needing from to accomplish your aim?**